

POTENTIAL MEDICAID POLICY CHANGE: HIFA WAIVER (Concept 4 of 4 as of 10-29-03)

Proposed policy: Develop and submit a proposal for an 1115 Health Insurance Flexibility and Accountability (HIFA) Demonstration Waiver that does the following:

1. Provides a Medicaid funded basic primary care health care benefit and a core set of Medicaid mental health services, including a limited pharmacy benefit, to some or all of the individuals currently served under the state's Mental Health Services Plan (MHSP);
2. Provides Medicaid funded dialysis services to individuals currently eligible for the state's End Stage Renal Program;
3. Where possible, revises the Medicaid benefits package for existing optional eligibility groups, such as the medically needy, in order to provide a primary care health care benefit and any other appropriate medical services (e.g. nursing home);
4. Where appropriate, and allowable, implements additional recipient cost sharing measures such as larger copayments for inappropriate emergency room visits and/or sliding fee-scales based on income;
5. Uses savings achieved from implementing 1 through 4 above to provide a limited primary health care benefit, that is not an entitlement, to some currently uninsured population such as children on the CHIP waiting list, parents of CHIP children or uninsured childless adults with incomes under 150% of poverty level; and
6. If possible, provides some or all of the new health care benefit package(s) through private health insurance.

Current practice:

State Funded Mental Health Services Plan: Montana spends about 5.5 million dollars per year in state funds on the Mental Health Services Plan (MHSP), a capped program of mental health services similar to those provided through Medicaid, excluding inpatient hospitalization. MHSP serves approximately 4,500 individuals per year who are not eligible for Medicaid, but are Seriously Mentally Ill and have incomes under 150% of poverty level. MHSP does not pay for primary health care and most of the individuals served do not have private health insurance.

State Funded End-Stage Renal Program: Montana currently spends \$100,000 per year on the End-Stage Renal Program, a 100% state general fund program which purchases services related to kidney dialysis, primarily drugs. The program serves approximately 100 people per year whose incomes must be fewer than 300% of poverty level. Unlike Medicaid, the End Stage Renal Program is not an entitlement. When the demand for services exceeds the appropriated resources, people who are eligible must wait until more money becomes available at the

beginning of the next fiscal year.

Current Uniform Medicaid Benefits/Requirements: Montana currently provides a limited Medicaid benefit package to the adults who become eligible through the TANF program. All of the other mandatory and optional Medicaid groups receive the same benefits package, without regard to how they became eligible. Copayments and cost sharing requirements are currently the same for all Medicaid eligibility groups.

Current Medicaid Entitlement: With the exception of residential and support services funded through any of the three Home and Community-Based 1915 (c) Waivers, all eligible individuals are entitled to any medically necessary service provided through the Montana Medicaid program, regardless of available funding.

Private Insurance: While the CHIP program provides eligible children with a primary care health benefit through private insurance, Montana Medicaid does not purchase any services through a private insurance model.

Proposed change in practice:

Enhance and expand MHSP services through HIFA: Add a basic primary health care package to the mental health services already available to Seriously Mentally Ill adults with incomes under 150% of poverty through MHSP. Provide the services to the current, or a yet to be defined, eligibility group as a capped entitlement under Medicaid, with an upper limit on expenditures and people served.

Expand the End Stage Renal Program through HIFA: Provide kidney dialysis and other related services already available under the end stage renal program as a capped entitlement under Medicaid. Such a change should enable the state to both save money and serve the entire group of individuals currently eligible for the state funded program, thereby eliminating the waiting list.

Adjust Medicaid benefits and cost sharing requirements for “Optional” eligibility groups: Consistent with the provisions of HIFA, review Montana’s benefit package and cost sharing requirements for the Medicaid Optional eligibility groups currently served in the state. Identify possible adjustments to the menu of services available and the level of cost sharing required for these populations. Implement any reasonable changes identified through the review process, taking into account the characteristics and needs of the specific Optional population, as well as the need to restrain the growth of future Medicaid expenditures, while continuing to meet the basic health care needs of the people served.

Use any general fund savings to expand health care coverage for currently uninsured low-income individuals: Use any general fund savings generated by restructuring existing Medicaid benefits and cost sharing requirements, and by funding the MHSP and End Stage Renal Program through Medicaid, to provide a basic package(s) of health care services to low-income people who currently do not have health insurance. Potential expansion populations might include: kids from

the CHIP waiting list; uninsured CHIP parents; and working low income childless adults without insurance.

Note: Several approved HIFA Waivers have enabled states to use monies from existing state-funded programs such as the End-Stage Renal Program or MHSP, to expand or enhance coverage and/or services through Medicaid. However, state's that have done so have been subject to a Maintenance of Effort (MOE) requirement by the federal government, mandating they continue to spend the amount of state funds currently devoted to those programs on HIFA related health care.

Limit expenditures for expanded coverage to available funding: Any expanded services or health insurance coverage funded through the HIFA Waiver will be subject to an upper-limit expenditure cap based on the available funding.

Explore the use of private insurance: As an alternative to a Medicaid fee-for-service model of service delivery, examine the potential to provide some or all of the HIFA Waiver expanded health care benefits and services through specially developed, Medicaid funded, private insurance policies.

Rational for the proposed change: A HIFA Waiver such as the one described here would enable Montana to do at least three things that would have a positive impact on delivery of health care in the state:

1. Take a first step toward creating a more flexible and responsive Medicaid program that will grow at a rate that is more likely to be sustainable across time;
2. Expand and enhance the services available under the state funded End Stage Renal Program and the Mental Health Services Plan; and
3. Decrease the number of people living in the state who do not have basic primary care health insurance coverage, through the more efficient use of the existing state general fund appropriation.

Estimated impact on Medicaid recipients:

While some current Medicaid recipients would see a change in the level of services they are entitled to receive and the amount cost sharing required, the overall number of people receiving Medicaid funded health care services would increase.

Estimated impact on Medicaid expenditures:

Any actions taken to reduce existing benefit levels and increase cost sharing requirements would act to restrain the future growth in Medicaid expenditures beyond the degree possible through the existing mechanisms available under current law. Any HIFA related Medicaid expansion would

be capped by the amount of money appropriated by the legislature and funded with savings from the existing Medicaid program, or with existing state funds from MHSP and the End Stage Renal Program.

Level of approval required:

A HIFA Waiver would require approval by the Governor's Office, Montana Legislature and the Secretary of the Department of Health and Human Services. The prospects for federal approval would be greatly enhanced by the full and active support of the members of Montana's Congressional delegation.

Reinvestment of savings (if applicable):

The federal government requires that the proposal be budget neutral. Savings will be reinvested enhanced services and expanded health care coverage as described in this proposal.

Administrative changes:

The proposal to redesign Montana's Medicaid funded health care service system that is outlined here is dramatic, complex and, quite possibly, controversial. To succeed it will require a great deal of time, effort and commitment from the leaders and staff of the Department of Public Health and Human Services, as well as the full administrative and political support of current and future Montana Governors and Legislatures. That support must include a commitment to ensuring that the political, human and other resources necessary to secure approval for, implement, and evaluate the proposed waiver are available to the department. Inevitably the Deputy Director, in his role as Medicaid Director, will be called on to take the lead in developing, submitting, implementing and, as importantly, assessing the impact of the waiver. A HIFA proposal will require a strong commitment of staff and other resources, as well as the direct time and attention of the administrators of the divisions most directly impacted by the proposal: Human and Community Services; Adult and Child Health Resources; and Addictive and Mental Disorders. Successful development and implementation of a HIFA Waiver is likely to require additional specialized resources from outside the department and a commitment on the part of state policy makers to ensure that these necessary resources are available.

Evaluation of policy change:

Montana has a compelling need to fully understand the human and fiscal impacts of a dramatic change in the state's health care delivery system, such as the ones described in this proposal. In addition to self interest, the federal government requires that states conduct a detailed analysis of the impact and effectiveness of an approved HIFA Waiver. Given the nature of the proposal, the analysis will likely include:

1. An assessment of the impact of any HIFA related policy changes on the health care needs of, and services to, existing and new eligibility groups;

2. an assessment of the direct impact of the policy changes on Medicaid and other state expenditures for health care services, including an assessment of the impact on expenditures for services provided to both new and existing eligibility groups, both with and without the waiver; and

3. An assessment of the impact of the waiver on the number of people without health insurance coverage in the state.

In addition to the state's evaluation activities, the federal government will secure its own independent evaluation of the waiver's efficacy.

Contact:

Mike Hanshew
Chuck Hunter
Dan Anderson

BACKGROUND: Health Insurance Flexibility and Accountability (HIFA) Initiative

In August of 2001 the U.S. Department of Health and Human Services announced a new initiative providing states with the opportunity to expand health insurance coverage to more individuals while containing costs. The Health Insurance and Accountability initiative gives states new flexibility to design programs that integrate their Medicaid and State Children's Health Insurance Programs (a.k.a. in Montana "CHIP"). Under HIFA states have an unprecedented ability to expand health care coverage by tailoring benefits packages that meet the needs of specific target populations, while containing costs and limiting the financial obligation of the state.

What is HIFA?

HIFA is a new form of Medicaid Waiver included under the existing 1115 Demonstration Waiver Authority granted to the Center for Medicare and Medicaid Services (CMS), the federal agency charged with administering Medicaid. The purpose of HIFA is to encourage states to explore ways to expand private and/or public health care coverage through creative proposals that go beyond the all or nothing approach that inhibits the use of Medicaid as a vehicle to address unmet health care needs. HIFA places special emphasis on expanding health care coverage to currently uninsured individuals with incomes under 200 of the federal poverty level.

What is Different About HIFA?

While much of what HIFA does is theoretically available under the existing 1115 Waiver authority, the creation of the initiative, with its submission guidelines and expedited review process, sends a clear signal to the states that CMS is open to, and encouraging, proposals that increase the availability of basic health care through the use of unique benefits

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packages for existing and non-traditional Medicaid eligibility groups. While Medicaid law currently allows states to provide an extensive array of medical services to a wide variety of eligibility groups, it generally requires that each eligibility group receive all of the medically necessary services offered. Some of the key features of HIFA are the ability it gives to states to:

1. Design more limited benefit packages to meet the health needs of some eligibility groups (no more “all or nothing”);
2. Require increased cost sharing for some eligibility groups (e.g. premiums and copays);
3. Limit or cap the state’s financial obligation for services to some eligibility groups; and
4. Provide limited benefits packages through private insurance.

Eligibility Groups:

HIFA does not adjust the benefits or eligibility of the mandatory eligibility groups (low income aged, disabled, children, etc.) that states are required to serve under the Medicaid state plan. HIFA does, however, identify two groups whose benefit packages may be adjusted with a waiver from CMS. They are:

Optional Populations: These are populations that may be covered under Medicaid or “CHIP” at the state’s option, regardless of whether or not they are currently covered. Examples of optional populations include families and children, pregnant women, aged and disabled individuals with incomes above the federal minimums for eligibility and the medically needy. “CHIP” children and their parents are also considered optional populations.

Expansion Populations: Expansion populations are those individuals not previously eligible for coverage under Medicaid or “CHIP”. Some examples of expansion populations include low income childless adults and pregnant women with incomes above 185% of poverty level. States can place expenditure or enrollment limits on services to these populations.

Note: Utah has an approved waiver that does limit the benefit package for some of the mandatory eligibility groups, but because it does it was approved as a regular 1115 Demonstration Waiver, not as a HIFA Waiver.

Benefits:

States can alter the benefits package offered to the optional and expansion eligibility groups. HIFA specifies that benefits for optional populations must minimally include hospital, physician, laboratory and x-ray, and well baby and well child services. It does not mandate a specific level for these services. Benefits for expansion populations must only include basic primary care services from physicians.

Cost Sharing:

HIFA allows for increased cost sharing for both the optional and expansion populations in the form of larger copays and premiums. Cost sharing for children cannot exceed 5% of family

income.

Budget Neutral/Funding:

As it the case with all waivers, states must demonstrate that federal expenditures under the proposed waiver will be less than or equal to federal expenditures without the waiver. The state must demonstrate that the additional cost of serving the proposed expansion populations will be offset in three areas. They are:

1. Savings achieved from providing reduced benefits package(s) to existing, or future, optional eligibility group populations;
2. Reallocation of a portion of state Disproportionate Share Hospital (DSH) funding; and
3. Unused federal “CHIP” allocation (states may chose to apply any unused portion of their federal SCHIP allocation to the budget neutrality test).

HIFA may not be used to simply refinance existing state funded health care programs. States wishing to expand existing state funded health care programs through HIFA will be subject to a Maintenance Of Effort (MOE) requirement.

Administrative Requirements:

As is the case with all 1115 Waivers, HIFA Waivers are awarded for five year periods. States are required to collect ongoing evaluation and outcome data. As part of the evaluation, HIFA requires that states document and track the number/percent of their population that is uninsured. CMS has the authority to contract for an independent evaluation of the waiver, but it is not a requirement.

What are Other States Doing?

A number of states, including Illinois, Maine, New Mexico, California and Oregon have already secured approval from CMS for HIFA Waivers. In addition, Utah has an approved 1115 Demonstration Waiver that includes many HIFA like features, but also limits the benefit package provided to the mandatory population. These states are providing expanded health care coverage to low income individuals through a variety of private and public models that offer limited benefit packages tailored to the health care needs of specific groups, while containing costs and limiting state expenditures. In addition to using benefits savings, many of the states have reallocated DSH funds, as well as unexpended SCHIP funds, in order to meet the budget neutrality test. Several states have used these waivers to impose higher cost sharing requirements, such as a twenty-five dollar co-payment for inappropriate emergency room visits. Utah and Illinois have used HIFA to expand access 100% state funded programs such as kidney dialysis, hemophilia, low income premium assistance and a state medical assistance program.

Does a HIFA Waiver make sense in Montana?

It appears that states are pursuing HIFA Waivers for three key reasons, all of which would seem to make sense in Montana as well. They are:

1. HIFA provides greater latitude to states to design a variety of health care benefit packages for the different eligibility groups served under the Medicaid program;
2. HIFA gives states the ability to provide expanded health care coverage for uninsured individuals while capping expenditures; and
3. HIFA gives states a vehicle through which to enhance or expand participation in 100% state funded health care programs, without creating an open-ended financial obligation for the state.